31.11.06.11

.11 Preexisting Conditions.

A. A carrier may not apply a preexisting condition provision to health care services for pregnancy or newborns.

B. For contracts issued or renewed on or after October 1, 2009, an insurer or non-profit health service plan may impose a preexisting condition provision in accordance with Insurance Article § 15-508, Annotated Code of Maryland.

C. A carrier may impose a waiting period from the date of application, in accordance with Insurance Article, §15-1208, Annotated Code of Maryland.

.06 Limitations and Exclusions.

A. A carrier shall apply the limitations and exclusions specified in §B of this regulation to the covered services specified in Regulation .03 of this chapter.

B. The following are exclusions and limitations to the covered services:

(1) Services that are not medically necessary;

(2) Services performed or prescribed under the direction of a person who is not a health care practitioner;

(3) Services that are beyond the scope of practice of the health care practitioner performing the service;

(4) Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;

(5) Services for which a covered person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan;

(6) The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury;

(7) Personal care services and domiciliary care services;

(8) Services rendered by a health care practitioner who is a covered person's spouse, mother, father, daughter, son, brother, or sister;

(9) Experimental services;

(10) Practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;

(11) In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures;

(12) Services to reverse a voluntary sterilization procedure;

(13) Services for sterilization or reverse sterilization for a dependent minor;

(14) Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services;

(15) Services incurred before the effective date of coverage for a covered person;

(16) Services incurred after a covered person's termination of coverage, including any extension of benefits;

(17) Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;

(18) Services for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law;

(19) Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups;

(20) Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

(21) Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;

(22) Inpatient admissions primarily for diagnostic studies, unless authorized by the carrier;

(23) The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in Regulation .03A(34) of this chapter;

(24) Except for covered ambulance services, travel, whether or not recommended by a health care practitioner;

(25) Except for emergency services, services received while the covered person is outside the United States;

(26) Immunizations related to foreign travel;

(27) Unless otherwise specified in covered services, dental work or treatment which includes hospital or professional care in connection with:

(a) The operation or treatment for the fitting or wearing of dentures,

(b) Orthodontic care or malocclusion,

(c) Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and

(d) Dental implants;

(28) Accidents occurring while and as a result of chewing;

(29) Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be medically necessary;

(30) Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be medically necessary;

(31) Inpatient admissions primarily for physical therapy, unless authorized by the carrier;

(32) Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery;

(33) Treatment of sexual dysfunction not related to organic disease;

(34) Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs;

(35) Organ transplants except those included under Regulation .03 of this chapter;

(36) Nonhuman organs and their implantation;

(37) Nonreplacement fees for blood and blood products;

(38) Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered service;

(39) Wigs or cranial prosthesis;

(40) Weekend admission charges, except for emergencies and maternity, unless authorized by the carrier;

(41) Out-patient orthomolecular therapy, including nutrients, vitamins, and food supplements;

(42) Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;

(43) Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy;

(44) Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution;

(45) Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person, unless the:

(a) Transplant recipient is covered under the plan and is undergoing a covered transplant, and

(b) Services are not payable by another carrier;

(46) Physical examinations required for obtaining or continuing employment, insurance, or government licensing;

(47) Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;

(48) Private hospital room, unless authorized by the carrier;

(49) Private duty nursing, unless authorized by the carrier;

(50) Treatment for mental health or substance abuse not authorized by the carrier through its managed care system, or a mental health or substance abuse condition determined by the carrier through its managed care system to be untreatable; and

(51) Services related to smoking cessation.

C. A religious organization may request and a carrier shall grant the request for an exclusion from coverage for a service mandated under the plan if the service is in conflict with the religious organization's bona fide religious beliefs and practices.

D. A religious organization that obtains an exclusion from coverage for a service mandated under the plan shall provide its employees reasonable and timely notice of this exclusion.

E. The carrier's premium rate for the plan may not be affected by the religious organization's exclusions from coverage for a service mandated under the plan.

F. An insurer or non-profit health service plan may impose a pre-existing condition exclusion as specified in Regulation .11 of this chapter.